

504

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

00495

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <i>Harlem</i> <i>Charles</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Harlem</i> COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>TOWN</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harlem</i> <i>Charles</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>Francis</i> <i>Richard</i> <i>Adams</i>		4. DATE OF DEATH <i>Jan</i> <i>23</i> <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>10/15/1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Seaman</i>		<i>U.S. Navy</i>	<i>Harlem</i>
13. FATHER'S NAME <i>John Adams</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS	
<i>No</i>		<i>Wm. Edgar P. Miller, 1124 N. 1st St.</i>	
16. SOCIAL SECURITY No. <i>None</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
<i>420.1</i> Immediate cause (a) <i>Coronary Thrombosis</i>			<i>1 hour</i>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) <i>Coronary Sclerosis</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <i>None</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		DATE SIGNED <i>1/23/56</i>	
SIGNATURE <i>William H. Kiser, M.D.</i>		ADDRESS <i>La Plata Maryland</i>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <i>1/26/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Harlem Baptist</i>		LOCATION (City, town, or county) <i>Harlem</i>	
DATE REC'D BY LOCAL REG. <i>1/24/56</i>		24. FUNERAL DIRECTOR <i>Harlem Funeral Home, 1124 N. 1st St.</i>	
REGISTRAR'S SIGNATURE <i>Julia H. Bascy</i>		ADDRESS	

RECEIVED

JAN 26 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00496

505
CERTIFICATE OF DEATH

Reg. Dist. No. 100

Items 4, Film G 201 8-21-56-ET.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>La Plata</u>				OR TOWN <u>Issue</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Baby "A"</u> (Middle) <u>Butler</u> (Last)				(Month) <u>2</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>		8. DATE OF BIRTH <u>January 1, 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>3</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>James Milton Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Viola Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Viola Butler</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>damage due to delivery</u>				3 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>				3 hrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1-56</u> , to <u>1-1-56</u> , that I last saw the deceased alive on <u>1-1-56</u> , 19 <u>56</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frederick Johnson, M.D.</u>				ADDRESS (Street, city, town, state) <u>La Plata Md</u> DATE SIGNED <u>1-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greg Street</u>		LOCATION (City, town, or county) (State) <u>La Plata, Md</u>	
24. REC'D BY REGISTRAR <u>Julia H. Porey</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>James Milton Thomas</u>		ADDRESS <u>Archant Funeral Home, La Plata</u>	
DATE <u>1/4/56</u>							

2166191230

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

NAME OF DECEASED		DATE OF BIRTH	
SEX		AGE	
RACE		EDUCATION	
OCCUPATION		MARRIED	
RESIDENCE		CITY	
STATE		COUNTY	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
DATE		PLACE	

BUREAU V. S.

JAN 9 1955

RECEIVED

RECEIVED

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. AND A COPY IS TO BE SENT TO THE COUNTY CLERK OF THE COUNTY WHERE THE DECEASED RESIDES.

1

INSTRUCTIONS

1 executed within **24 hours** after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00497

596

CERTIFICATE OF DEATH

Items 4, 8 Film G 201, 8-21-56, E.T.

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN La Plata				TOWN Issue			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) Baby "B" Butler				4. DATE OF DEATH (Month) January (Day) 21 (Year) 1956			
5. SEX Male		6. COLOR OR RACE colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S		8. DATE OF BIRTH January 1, 1956	
				9. AGE last birthday yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Milton Thomas				14. MOTHER'S MAIDEN NAME Agnes Viola Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Viola Butler			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
976X IMMEDIATE CAUSE (A) Respiratory (extreme)				INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-56 , 1956 , to 1-1-56 , 1956 , that I last saw the deceased alive on 1-1-56 , 1956 , and that death occurred at 7:30 p.m. , from the causes and on the date stated above.							
SIGNATURE Frederick Johnson M.D.		ADDRESS (Street, city, town, state) La Plata, Md.		DATE SIGNED 1-3-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/4/56		NAME OF CEMETERY OR CREMATORY Holy Ghost		LOCATION (City, town, or county) (State) Issue, Md.	
24. REC'D BY REGISTRAR DATE 1/4/56		REGISTRAR'S SIGNATURE Julius H. Posey		25. FUNERAL DIRECTOR'S SIGNATURE Archibald Funeral Home, La Plata		ADDRESS	

100-100

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, cause of death, and place of death. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

JAN. 9 1956

RECEIVED

RECORDS SECTION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
RECORDS SECTION
JAN 10 1956
100-100

1

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

1 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00498

507

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HUGHESVILLE</u>		<u>500RS</u>		TOWN <u>HUGHESVILLE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>LILLIAN</u> <u>MAE</u> <u>CANTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 28</u> <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W - U.S.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 8, 1876</u>		9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD T. LUSBY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA JANE HILLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. PAUL LONG</u> <u>HUGHESVILLE, MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>ARTERIO-SCLEROTIC HEART DISEASE</u>						<u>2 WEEKS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ACUTE LEFT VENTRICULAR FAILURE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>GENERALIZED ARTERIO-SCLEROSIS</u>						<u>10 YEARS</u>	
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/14</u> , 19 <u>56</u> , to <u>1/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>56</u> , and that death occurred at <u>4:00</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John H. Guffey</u> M.D.				ADDRESS (Street, city, town, state) <u>HUGHESVILLE, MD</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEROF <u>2-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Old Field</u>	
24. REC'D BY REGISTRAR <u>2/1/56</u>				REGISTRAR'S SIGNATURE <u>Julia W. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The South Funeral Home</u>	
DATE				ADDRESS			

CERTIFICATE OF DEATH

Form 100-101

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

BUREAU V. S.

FEB 10 1956

RECEIVED

157-1000-101

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

508 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00499
 Reg. Dist.

No. 100

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Charles	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Waldorf	COUNTY	Charles
TOWN		CITY (If outside corporate limits write RURAL and give nearest town)	Bryantown
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural, give location)
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	LOUIS	(Month)	Jan.
(First)	McKINLEY	(Day)	19
(Middle)	EDELEN	(Year)	1956
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
M	Negro	Single	9-26-1925
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Construction	Washington, D. C.	U. S.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Bernard Cook		Mary (Maiden name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		17. INFORMANT & ADDRESS:	
No		Sheriff office, Charles County, Maryland	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	
929.3 Immediate cause (a) DUE TO		Brownie	
Antecedent cause(s) (b) DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
0			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY	
		Home & Farm	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
		M.	
21f. HOW DID INJURY OCCUR?		Slipped on ice at edge of swimming pool & fell in. Water was 8' deep.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER	
R. E. Edele		DEPUTY MEDICAL EXAMINER	
		M. D.	
23. BURIAL, CREMATION, REMOVAL (Specify):		24. FUNERAL DIRECTOR	
Burial		The Hunt Funeral Home	
DATE THEREOF		LOCATION (City, town, or county)	
1-23-1956		Bryantown, Maryland	
NAME OF CEMETERY OR CREMATORY		ADDRESS	
St Mary's Cemetery		1-20-56	
DATE REC'D BY LOCAL REG.		1/23/56	
REGISTRAR'S SIGNATURE		J. H. D. Casey	

BUREAU V. S.

JAN 25 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

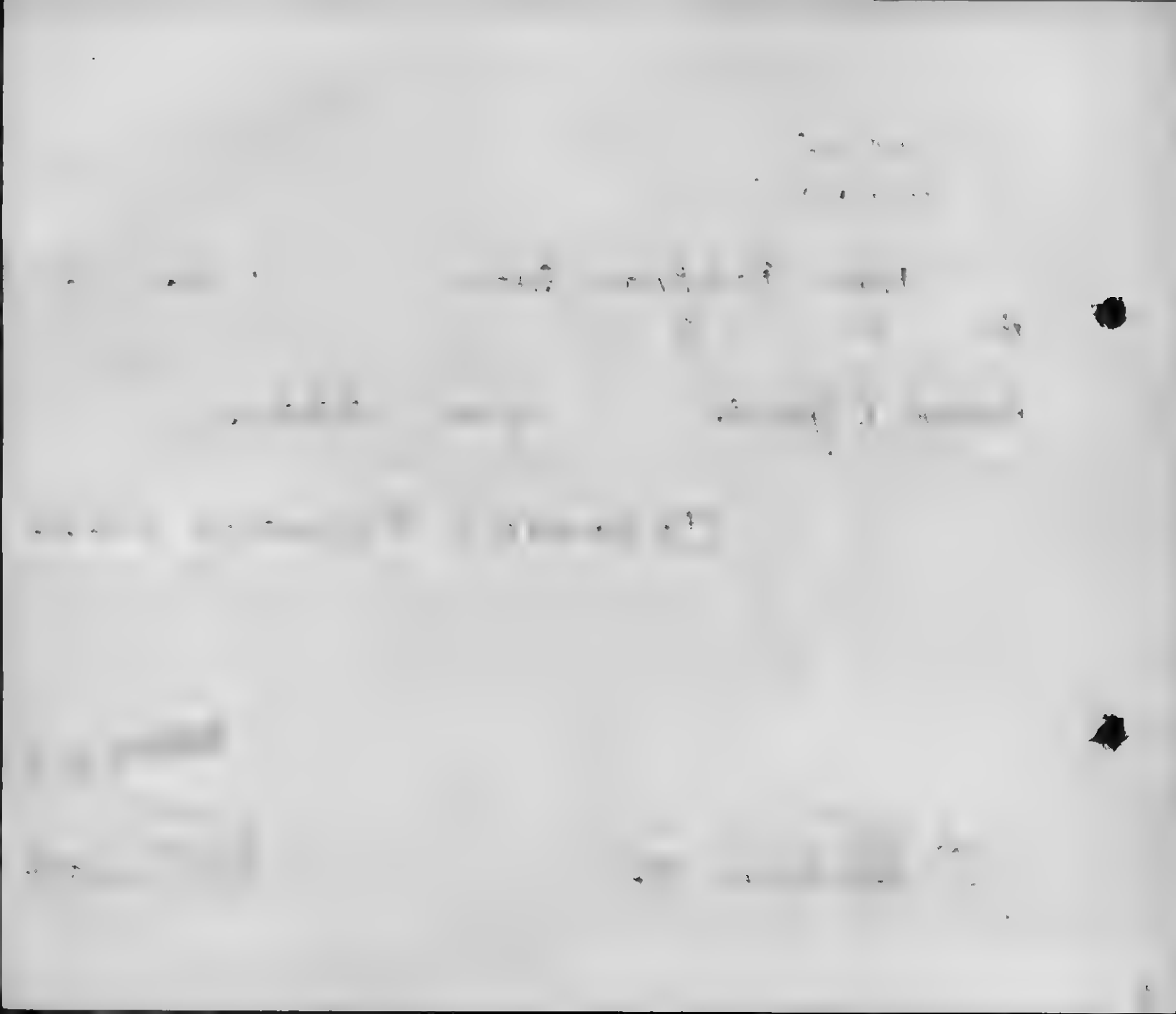
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00500

Reg. Dist.

No. 105

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>WALDORF</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Waldorf, Md.</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>EARL</u> (First) <u>Pembrook</u> (Middle) <u>Gates</u> (Last)				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>26</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>1-9-1898</u>	9. AGE last birthday: <u>58</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Peter P. Gates</u>				14. MOTHER'S MAIDEN NAME: <u>IDA ADAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Frank P. Gates Jr. Waldorf Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>CORONARY OCCLUSION</u> DUE TO				<u>1-26-56</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify, that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. H. Delaney MD.</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>1-26-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF: <u>1-28-56</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Pauls Cemetery</u>		LOCATION (City, town, or county) (State) <u>Waldorf Md</u>	
DATE REC'D BY LOCAL REG. <u>1-28-56</u>		REGISTRAR'S SIGNATURE <u>M. H. ...</u>		24. FUNERAL DIRECTOR <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf Md</u>	



1

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 101

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00501

510

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>La Plata</u>				TOWN <u>Bel Alton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Marian</u>		(Middle) <u>Dorothy</u>		(Last) <u>Goldsmith</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Nov. 9, 1908</u>	
				9. AGE last birthday <u>47</u> yrs.		10. IF UNDER 1 YEAR (Month) (Day) (Year) <u>Jan. 15 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Pilkerton</u>				14. MOTHER'S MAIDEN NAME <u>Marian Oliver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Elmer Goldsmith, Bel Alton, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>						4 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Squamous Cell Epithelioma of Endocervix with Multiple Metastases.</u>						1 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Uremia</u>						1 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Intestinal Obstruction with Colostomy</u>						6 weeks	
19a. DATE OF OPERATION <u>Sept. 9, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Acute Ileal and Colonic Obstruction; Extensive Carcinoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 7, 1955</u> , to <u>1-15-56</u> , that I last saw the deceased alive on <u>1-15-56</u> , and that death occurred at <u>3:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Barbara Jarboe</u>				M.D. <u>La Plata, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Good Burial</u>		DATE THEREOF <u>1-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ignatius</u>		LOCATION (City, town, or county) (State) <u>Bel Alton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julia H. P. P.</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <u>Huntt Funeral Home, 1000 Waldorf, Md.</u>	
DATE <u>1/16/56</u>							



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00502

511

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		STATE <u>md</u> COUNTY <u>Charles</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Cobb Island</u>		LENGTH OF STAY (in this place)		OR TOWN <u>Cobb Island</u>		STREET ADDRESS (if rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John Hann Jacobs</u>				<u>1 7 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 9 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D C</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas P Jacobs</u>				14. MOTHER'S MAIDEN NAME <u>Louise Boon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Agnes L Jacobs Cobb Island md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Lymphatic Leukemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4. 55</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>4</u> to <u>1-7</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1-7</u> , 19 <u>56</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. Hedden</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		LOCATION (City, town, or county) (State) <u>Wayside md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julia Hasey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home Inc</u>		ADDRESS <u>Laplace</u>	
DATE <u>1/10/56</u>							



1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

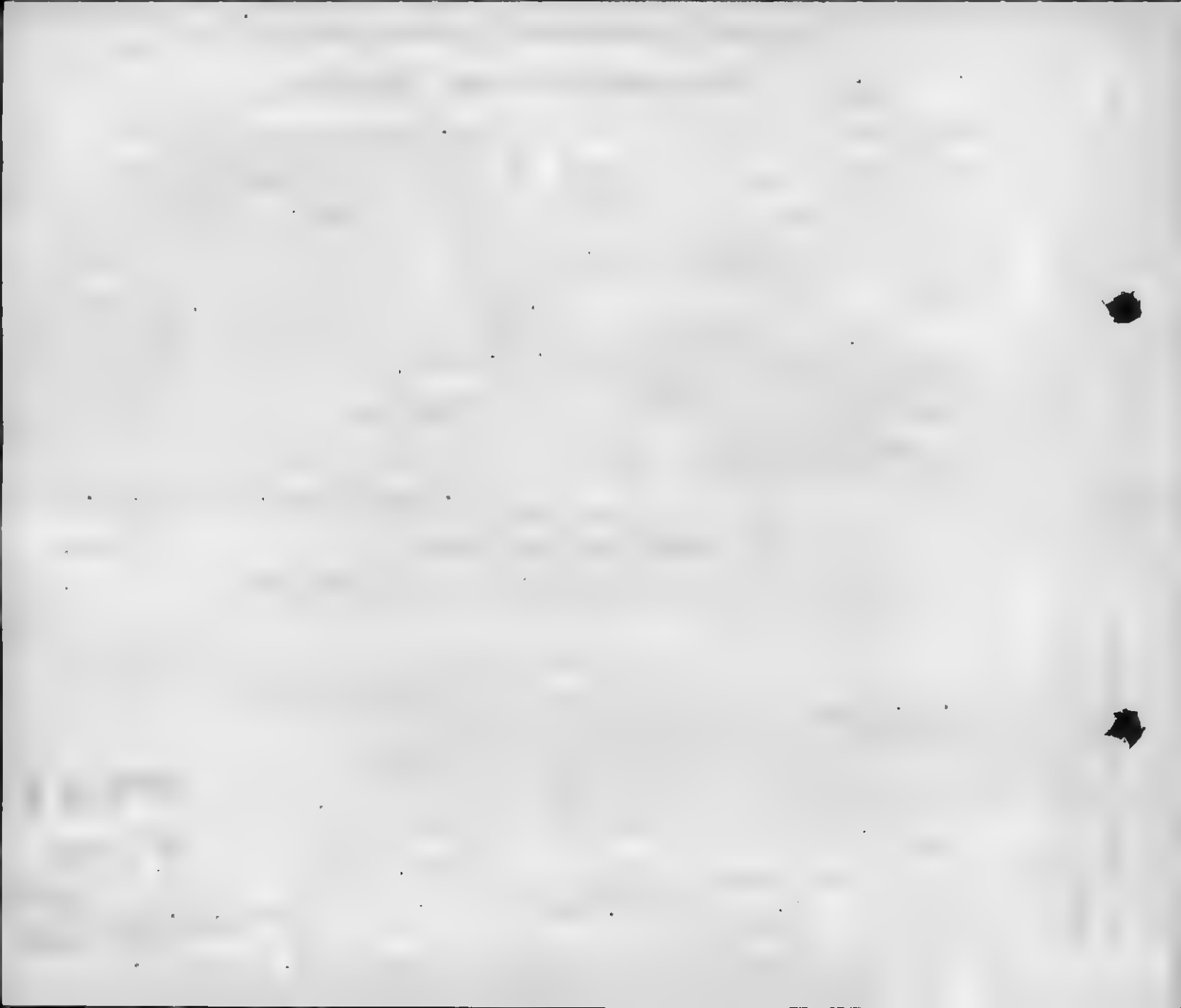
00503

512

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN La Plata				TOWN Bryantown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) George Jameson				4. DATE OF DEATH (Month) (Day) (Year) Jan. 11, 1956			
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 11, 1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Jameson				14. MOTHER'S MAIDEN NAME Cecelia Wheatly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS M. Louise Jameson, Bryantown, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Generalized Carcinomatosis						2 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) Adenocarcinoma of Stomach with Metastases						3 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Acute Intestinal Obstruction						1 week	
19a. DATE OF OPERATION Nov. 11, 1955		19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Stomach with multiple metastases				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 3, 1955 , to Jan. 10, 1956 , that I last saw the deceased alive on Jan. 10, 1956 , and that death occurred at 1:25 A.M. from the causes and on the date stated above.							
SIGNATURE Harman Jarboe				M.D. La Plata, Maryland		DATE SIGNED Jan. 11, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-13-56		NAME OF CEMETERY OR CREMATORY St. Marys		LOCATION (City, town, or county) (State) Bryantown, Md.	
24. REC'D BY REGISTRAR 1/13/56		REGISTRAR'S SIGNATURE Julia H. Posey		25. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		ADDRESS	



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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00504

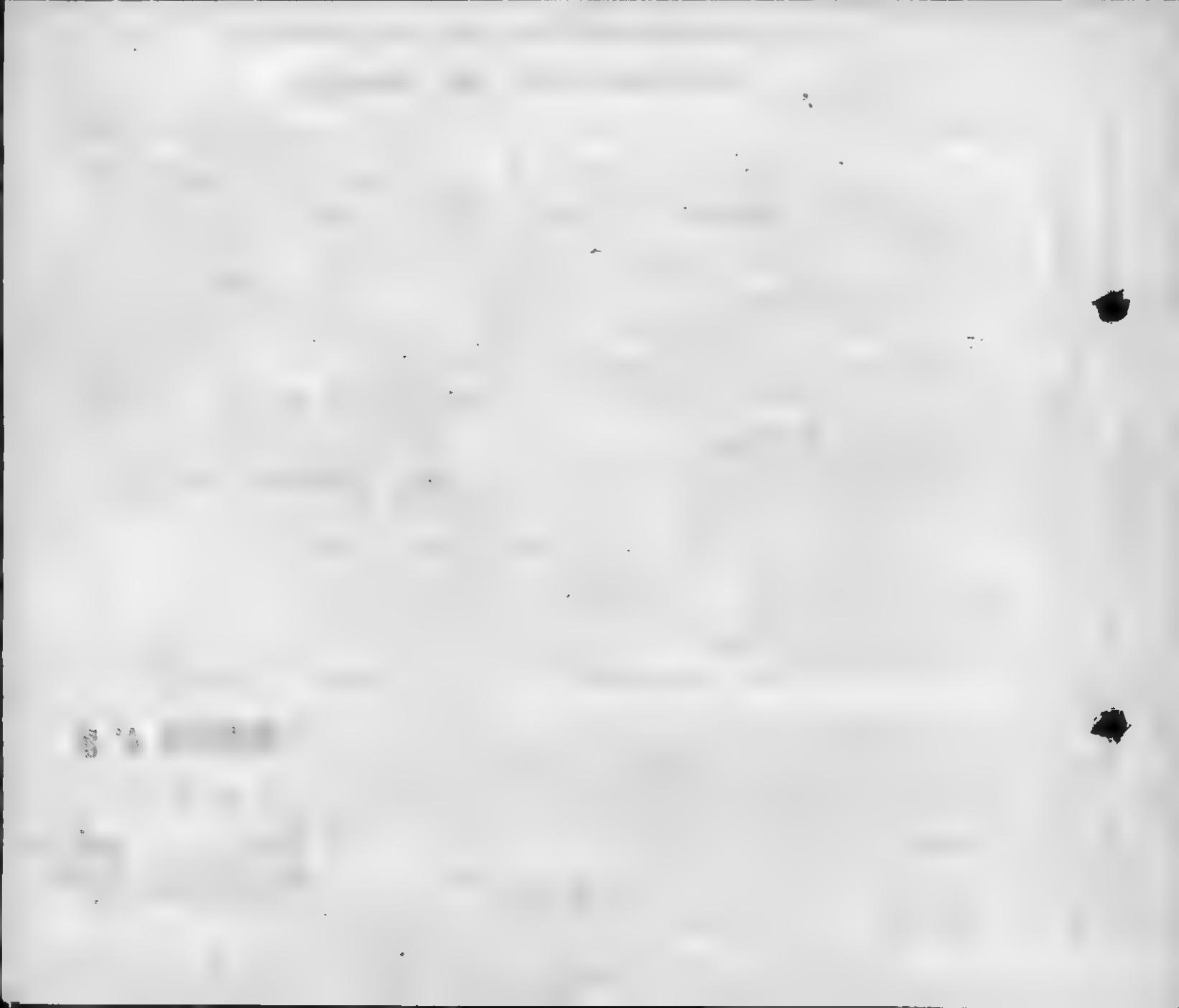
513

CERTIFICATE OF DEATH

Item 8, Film G191 1-13-56 et

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CHARLES		STATE MD.		COUNTY CHARLES			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN RURAL-WALDORF		LIFE		TOWN RURAL-WALDORF			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ELNORA McPHERSON				JAN 3 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F.	N	W.	Mar. 3, 1875	81 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		HOME		Maryland		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Butler				Charlotte Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO				MRS ELNORA PINKNEY			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) MYOCARDIAL FAILURE						1 day	
ANTECEDENT CAUSE(S) DUE TO (B) CARDIO-VASCULAR RENAL DISEASE						YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB. 10, 1955 to JAN 2, 1956 , that I last saw the deceased alive on JAN 2, 1956 , and that death occurred at 3:25 PM , from the causes and on the date stated above.							
SIGNATURE Dale M. Fern				ADDRESS (Street, city, town, state) Aquasco, Md		DATE SIGNED 1/3/56	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		1/6/56		ST PAUL'S		WALDORF, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				The Hunt Funeral Home - Waldorf			
DATE 1-4-56							



1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

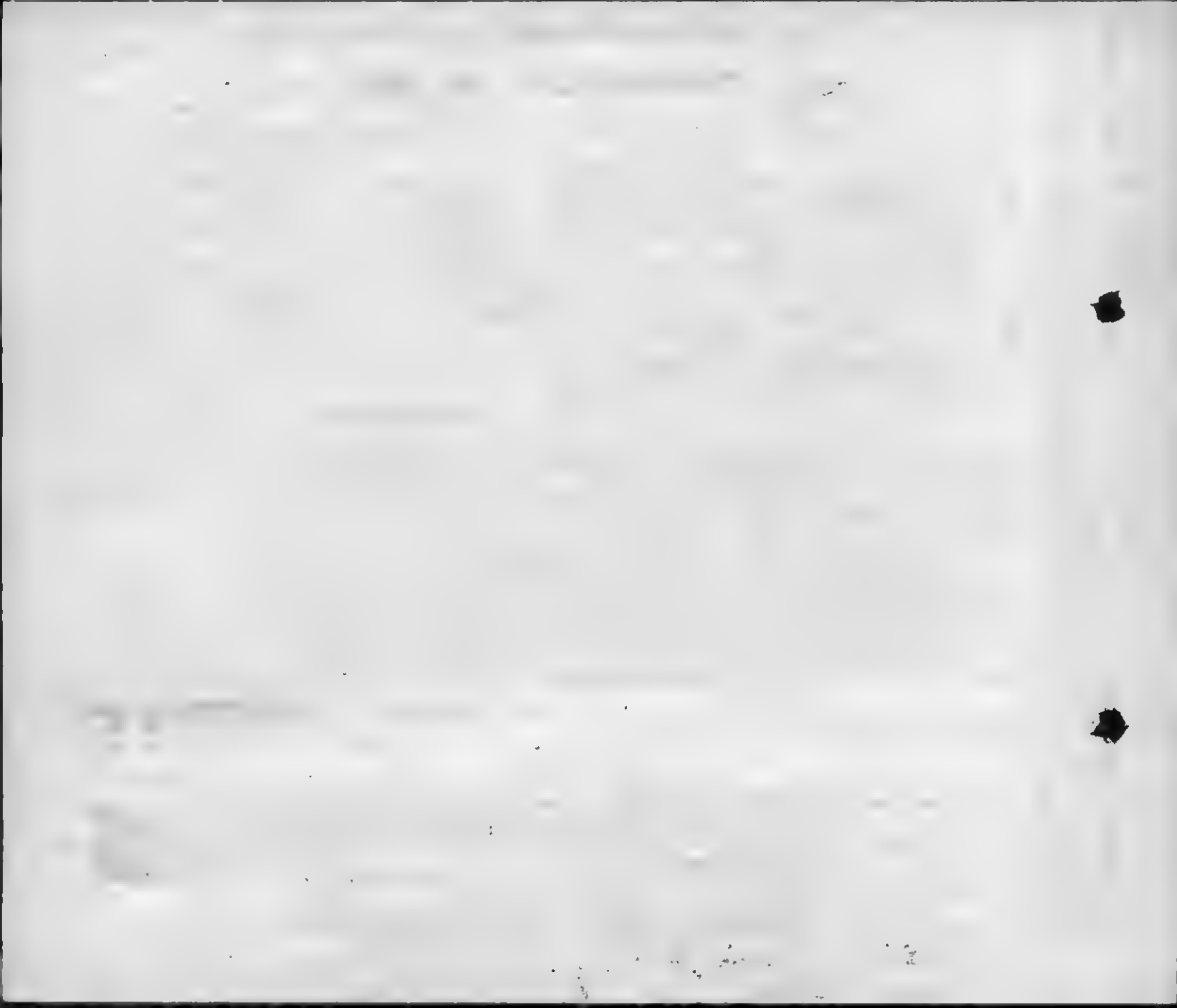
00505

514

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>La Plata Md</i>				TOWN <i>Huntingtown md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phys Mem. Hopt.</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Susan</i> (First) <i>Morgan</i> (Middle) <i>Morgan</i> (Last)				4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>8</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Dec 27 1906</i>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months <i>12</i> Days <i>12</i>	IF UNDER 24 HRS. Hours <i>12</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Charles Co md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wilmer C. Morgan</i>				14. MOTHER'S MAIDEN NAME <i>Dorothy Morgan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <i>Wilmer C. Morgan. Calvert Co</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>respiratory failure</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <i>cerebral hemorrhage at birth</i>						10 min	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)						8 days	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>29 dec</i> , 19 <i>55</i> , to <i>8 jan</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>7 jan</i> , 19 <i>56</i> , and that death occurred at <i>4:30A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>J. M. Johnson</i>				ADDRESS (Street, city, town, state)		DATE SIGNED <i>1-8-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <i>1-11-56</i>		NAME OF CEMETERY OR CREMATORY <i>St. Joseph</i>		LOCATION (City, town, or county) (State) <i>La Plata, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Julia H. Baxey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Morgan</i>		ADDRESS <i>Calvert Funeral Home 212 La Plata</i>	
DATE <i>1/11/56</i>							



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00506

515

CERTIFICATE OF DEATH

Reg. Dist. No. 100

Iter 7, P'm 0191 1-17-56 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Lafayette</i>		TOWN <i>Chesee Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phy. Munz. Hopt.</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>Francis A. Penn</i>		<i>Jan 8 1956</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>Aug 27, 1884</i>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>71</i> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Farmer</i>			<i>Md</i>
12. CITIZEN OF WHAT COUNTRY			
<i>USA</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Alfred C Penn</i>		<i>Mary Bailey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS			
<i>Edna L Wins</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<i>611X IMMEDIATE CAUSE (A) Cardio failure</i>			<i>1 year</i>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<i>Prostatitis, uremia,</i>			<i>5 years</i>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1-6</i> , 19 <i>56</i> , to <i>1-8</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1-8</i> , 1956, and that death occurred at <i>6:00P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>R. Johnson</i>		ADDRESS (Street, city, town, state) <i>La Plata, Md.</i>	
DATE <i>1/10/56</i>		DATE SIGNED <i>1-8-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>1-10-56</i>	<i>Holy Ghost</i>	<i>Issue Md</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
	<i>Julia H. Bessy</i>	<i>Arthur Funeral Home Inc. La Plata</i>	



1

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

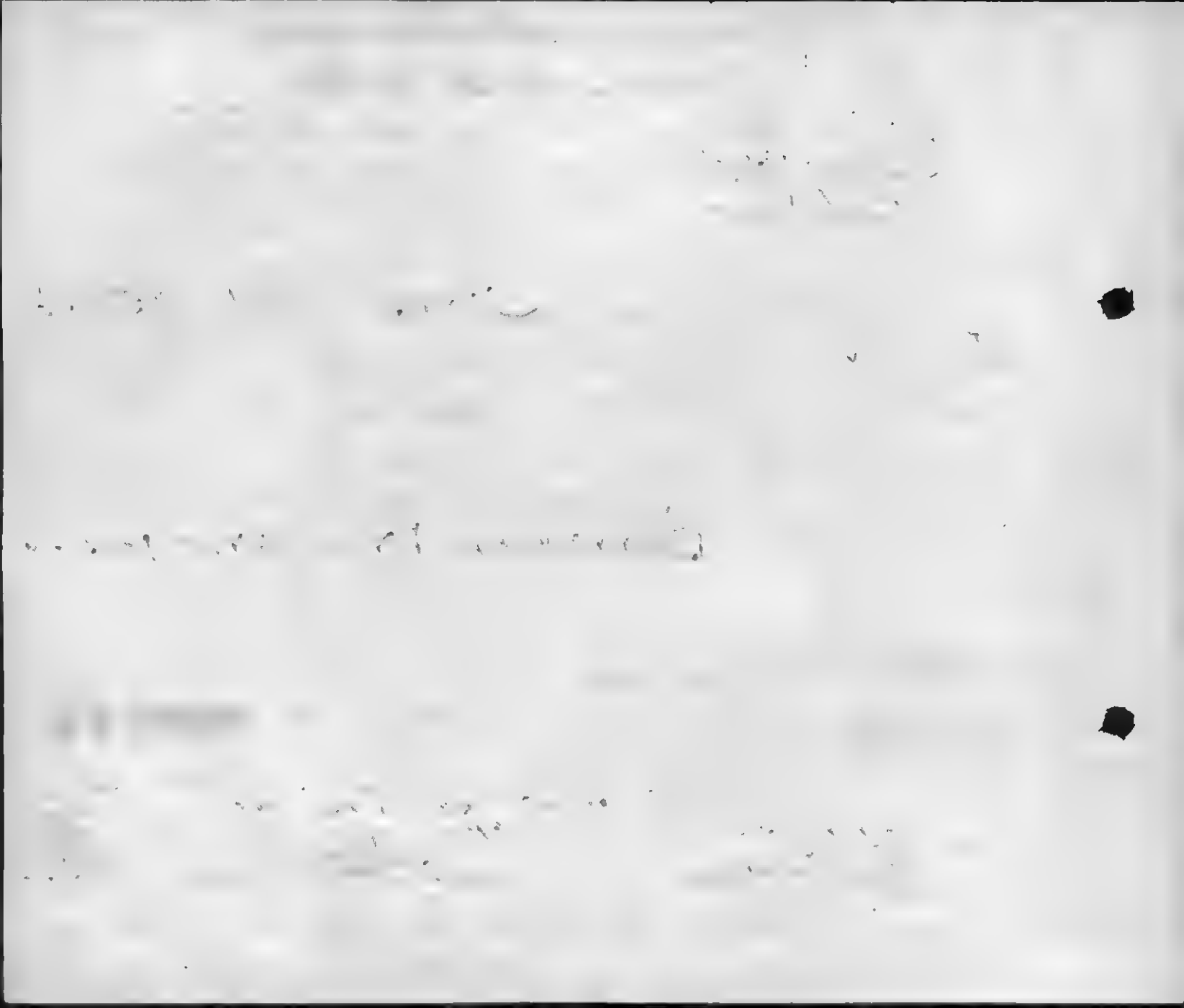
516

CERTIFICATE OF DEATH

00507

Reg. Dist. No. 104

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rock Point</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rock Point</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MAMIE LOMAX SIMMS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 25 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 13 1876</u>
9. AGE last birthday <u>79</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>1 25 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Lomax</u>		14. MOTHER'S MAIDEN NAME <u>Alice Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Alice J. McNulty</u> <u>Rock Point</u> <u>MD</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>491X IMMEDIATE CAUSE (A) BRONCHIAL PNEUMONIA</u> DUE TO ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(B) (C)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-23-56</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-10-56</u> , to <u>1-23-56</u> , that I last saw the deceased alive on <u>1-22-56</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>R. J. Edelen</u> M.D. ADDRESS (Street, city, town, state) <u>La Plata Md</u> DATE SIGNED <u>1-25-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-28-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		LOCATION (City, town, or county) (State) <u>Newport, MD</u>	
24. REC'D BY REGISTRAR <u>Jan 31, 1956</u>		REGISTRAR'S SIGNATURE <u>Thom. J. Green</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

517

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

00508

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Tompkinsville</u> TOWN <u>Tompkinsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Tompkinsville</u> TOWN <u>Tompkinsville</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Smallwood</u> (Last)		4. DATE OF DEATH (Month) <u>1-</u> (Day) <u>12</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>1-12-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday If under 1 year: Months <u>4</u> Days <u>37</u> If under 24 hrs: Hours <u>4</u> Mins. <u>37</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ambrose Smallwood</u>		14. MOTHER'S MARDEN NAME <u>Mary Genevieve Fowler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X Immediate cause (a) Premature Delivery

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

8 hrs. 39 min

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 1/12/56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

90VVVVVVX5

BUREAU V. S.

JAN 16 1952

RECEIVED

00509

MARYLAND STATE DEPARTMENT OF HEALTH

518

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH - COUNTY <u>Charles</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pamper</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pamper</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pamper</u>		STREET ADDRESS <u>Pamper</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY ANITA SWANN</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>22</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>8-31-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>4</u> yrs. <u>4</u> months <u>22</u> days <u>22</u> hours <u>22</u> min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Theodore Swann</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pearl Proctor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>1</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

795.5 Immediate cause (a) <u>Unknown</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1-22-56</u>
Antecedent cause(s) (b) <u>Only want to be with parents</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>died at 2 AM. Not ill previously</u>	<u>1-22-56</u>

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE [Signature] (Degree or title) MD ADDRESS [Signature] DATE SIGNED 1-22-56

23. BURLIN, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/24/56</u>	NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>	LOCATION (City, town, or county) (State) <u>Pamper, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/22/56</u>	REGISTRAR'S SIGNATURE <u>Julia H. Ware</u>	24. FUNERAL DIRECTOR <u>Archant Funeral Home, Lotts, Md.</u>	ADDRESS <u>[Signature]</u>

1000192405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1936

RECEIVED